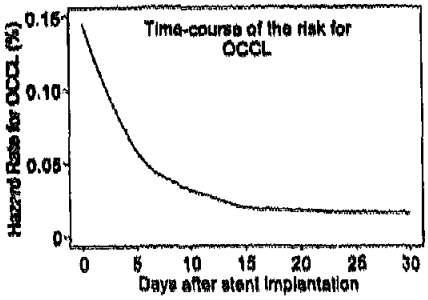
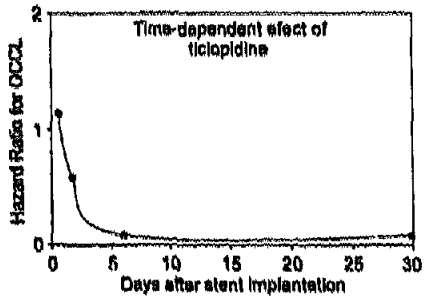
Methods: Clinical, angiographic and procedural data were prospectively recorded. OCCL was verified by angiography or autopsy.

Results: The rate of OCCL was 2.3% and was associated with major cardiac events in 97%. Significant risk factors for OCCL by Cox analysis were residual dissection (OR 10.2 [4.9–21.4]), overlapping stents (OR 1.9 [1.04–3.60]) and postprocedural therapy without ticlopidine (OR 5.2 [2.4–11.3]). The risk for OCCL fell sharply after one week (left graph). Ticlopidine was able to show its full protective effect not before the third day after the procedure (right graph).





Conclusions: The risk of OCCL depends mostly on the final result of stenting and poststenting therapy. Ticlopidine needs 2–3 days before demostrating its full protective effect.

1032-86 Pretreatment With Ticlopidine Reduces Non-Q-Wave Myocardial Infarctions Following Intracoronary Stenting

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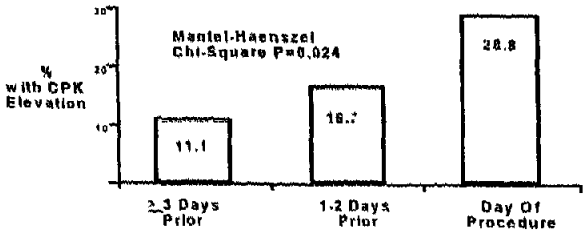
Background: Peri-procedural non-Q MI's with PTCA are associated with an increased risk of late mortality. Aggressive antiplatelet therapy reduces the risk of these events. We investigated whether pretreatment with ticlopidine reduced the incidence of non-Q wave MI's following stenting.

Methods: The medical records of 175 patients who electively received a stent and were pretreated with ticlopidine were evaluated.

Findings: 26% of these patients were treated with ticlopidine for 3 or more days prior to the intervention, 46% for 1–2 days prior, and 28% on the day of the procedure. Clinical and procedural characteristics were similar in all 3 groups. Non-Q wave MI (CPK >210 IU/L) occurred significantly less frequently with increasing duration of therapy (Figure).



Conclusion: Ticlopidine therapy prior to stenting decreases the incidence of non-Q wave MI's in a dose-dependent manner, suggesting a critical role for platelet inhibition in attenuating peri-procedural MI's.

1032-87 Ticlopidine-Aspirin as Antithrombotic Regimen for Intracoronary Stenting for Unstable Angina: Is there a Need for Further Antiplatelet Therapy?

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Prior studies have shown significant improvement of the results of balloon PTCA in the setting of unstable angina using abciximab. Nonetheless in these studies the use of intracoronary stenting was limited. The aim of our study was to assess the in-hospital results of intracoronary stenting with ticlopidine-aspirin therapy in unstable angina patients and to determine predictors of the occurrence of major complications.

We studied 179 consecutive patients (144 men, mean age 64 ± 11 years) with PTCA from November 1994 to December 1996, without planned use of abciximab. According to the Braunwald classification, 32 pts (18%) were in class I, 98 (55%) in class II and 49 (27%) in class III, in addition 15 pts (8%) had post myocardial infarction unstable angina. Indications for stenting were: bail-out in 13 pts (7%), suboptimal results in 124 pts (69%) and elective placement in 42 pts (24%). In addition, 10 patients had unplanned use of abciximab during the PTCA procedure. A major complication (death, Q-wave myocardial infarction, non Q-wave myocardial infarction) occurred in 13 pts (7.3%) and clinical success of the procedure (technical success of stent placement without major complication) was achieved in 89%. None of the patients underwent emergency CABG. Major complication rate was 0% for class I pts, 6.1% for class II pts and 14.1% for class III pts ($p < 0.04$). On x-variate analysis, predictors of in-hospital major complications were: LVEF ($p < 0.04$), stent indication ($p < 0.01$) and unstable angina class ($p < 0.06$). Considering post-myocardial infarction angina, major complication rate was 5.1% in non class C pts and 27% in class C pts ($p < 0.01$), this difference remained significant even when bail-out procedures were excluded ($p < 0.01$).

Thus, the major complication rate of coronary stenting is high in class III or C pts, despite the combined use of combined ticlopidine and aspirin. In such pts, the use of abciximab might be of particular interest..

1032-88 Heparin Does Not Prevent Acute Stent Thrombosis After Elective Intracoronary Stent Implantation

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Background: Several studies have reported that antiplatelet therapy decrease stent thrombosis after elective stent implantation. If coagulation activity dose not act as the main factor for acute stent thromoosis, heparin will have no influence on the thrombosis.

Methods: All patients were pre-treated with ticlopidine 200 mg and aspirin 160 mg more than 2 days before the elective stent implantation. During the procedure we administered heparin 10,000 IU. After stenting we randomized to either a group inhibiting the heparin by protamine 100 mg or a saline group. We followed them for 3 days after and compared them for ACT, major bleeding, and cardiac events (acute stent thrombosis, death).

Results: are summarized in the table below:

	Protamine group	Saline group	P
n	30	31	
ACT (second)			
5 min	148 ± 39	318 ± 78	<0.001
3 hour	123 ± 20	202 ± 50	<0.001
Complications			
Minor bleeding	0	4	0.04
Thrombosis	0	0	NS

Conclusion: The group using protamine did not increase acute stent thrombosis. Heparin dose not play the main factor for preventing acute stent thrombosis after elective intracoronary stent implantation.

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